No. 86-1023

IN THE

Supreme Court of the United States

October Term, 1986

BLUE CROSS ASSOCIATION and BLUE CROSS/ BLUE SHIELD OF GREATER NEW YORK,
Petitioners,

—and—

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

—against—

GROUP HEALTH INCORPORATED,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENT GROUP HEALTH INCORPORATED IN OPPOSITION

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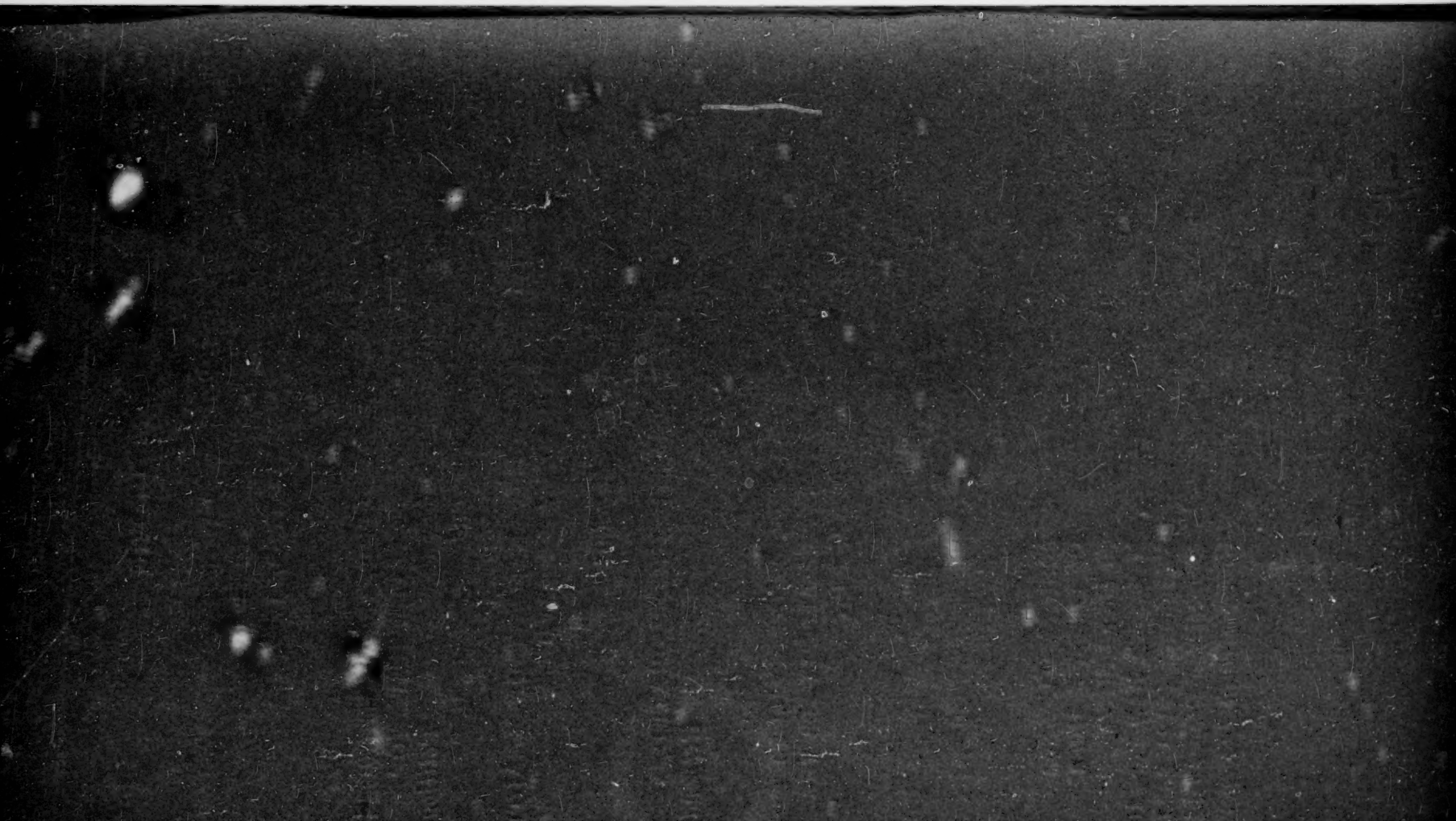

Question Presented

Whether the District Court's order denying the defendants' motion for summary judgment is immediately appealable under the circumstances of the instant case, in which a private corporation that is a subcontractor of a federal agency claims that it should be deemed a federal official for purposes of a grant of official immunity.

Statement Pursuant To Rule 28.1

There are no parent companies, subsidiaries or affiliates of respondent Group Health Incorporated.

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BRIEF FOR RESPONDENT GROUP HEALTH INCORPORATED IN OPPOSITION

Statement Of The Case

Procedural History

Group Health Incorporated ("GHI") brought this action in New York State Supreme Court against de-

fendants Blue Cross Association (the "Association"), now known as the Blue Cross and Blue Shield Association, and Blue Cross/Blue Shield of Greater New York ("Blue Cross"), now known as Empire Blue Cross and Blue Shield, Inc.

In this action GHI seeks to hold intermediaries in the Medicare program responsible for their own negligence in failing to follow proper procedures, which negligence resulted in an unauthorized and incorrect, written ruling by Blue Cross with respect to GHI. GHI is not seeking any recovery from the Medicare program or from the Secretary ("Secretary") of the United States Department of Health and Human Services ("HHS"). Rather, in its complaint GHI has asserted claims for negligence, misrepresentation, and breach of warranty of authority directly against the private defendants Blue Cross and the Association. (A. 9-21.) [1]

Defendants removed this action from state court to the United States District Court for the Southern District of New York, pursuant to the filing of a Verified Petition for Removal (the "Petition"). (A. 71-74.) Defendants stated in their Petition that removal was pursuant to 28 U.S.C. § 1442. Section 1442(a)(1) provides in relevant part for removal by "an officer of the United States or any agency thereof, or person acting under him, for any act under color of such office . . . ." (A. 72.)

Defendants served answers to GHI's complaint. (A. 93-103, 116-125.) Although each answer asserted various affirmative defenses, neither corporate defendant pled the affirmative defense of official immunity. (A. 102-03, 125.)

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[1] References to the Joint Appendix submitted to the Court below are denoted by "A." followed by the page number of the Joint Appendix.

Thereafter GHI moved to remand (A. 129) and HHS moved to intervene as a party defendant. (A. 133-34.) Included with HHS' moving papers was its answer. (A. 135-39.) As with the corporate defendants HHS did not allege official immunity as a defense to GHI's action. In their memorandum of law in opposition to GHI's motion to remand, the corporate defendants argued that they were entitled to remove as "person[s] acting under" the Secretary of HHS. Defendants did not claim that they were federal officers and in fact specifically disclaimed being an "officer of the United States". (Defendants' Memorandum of Law in Opposition to Plaintiff's Motion for Removal, dated April 2, 1982, p.8.) On June 13, 1984 the United States District Court for the Southern District of New York (Sweet, J.) denied GHI's motion to remand and granted HHS' motion to intervene by permission. (A. 140-49.) HHS had also moved to intervene as of right, but this was denied. (A. 146-49.)

Subsequently, the District Court consolidated the instant action with GHI's action against the United States, entitled *Group Health Incorporated* v. *United States of America and Otis R. Bowen*, 84 Civ. 2917 (PKL) ("*GHI* v. *United States*"). GHI's action against the United States alleges that the government is liable for the negligent and wrongful acts of Blue Cross, the Association and HHS under the Federal Tort Claims Act ("FTCA").

Following limited discovery, the corporate defendants moved on November 5, 1984 for summary judgment. (A. 157-58.) In their memorandum of law in support of the motion for summary judgment, the corporate defendants made no claim that they were federal officials and therefore entitled to immunity. Rather, as grounds for their motion, the corporate defendants asserted that GHI's claims were barred by sovereign immunity and that, as a matter of law, GHI could not establish reliance on Blue Cross' incorrect and unauthorized ruling. GHI opposed the

motion and submitted a memorandum of law in opposition, dated January 3, 1985. On the application of the corporate defendants and HHS, the District Court ordered that discovery be held in abeyance pending its determination of the motion for summary judgment. (A. 47.) Subsequently HHS submitted a Memorandum dated April 17, 1985 "in support of" the corporate defendants' motion for summary judgment. HHS itself made no motion. In the HHS memorandum, the argument was made for the first time that the corporate defendants should be "deemed" officials and should then be extended official immunity. By opinion filed August 16, 1985, the District Court (Leisure, J.) denied all aspects of that portion of the corporate defendants' motion for summary judgment that was directed to claims 1 through 5 of GHI's complaint. (Pet. App. B-1 to B-24.)

The corporate defendants and HHS appealed to the United States Court of Appeals for the Second Circuit from the District Court's denial of summary judgment. They alleged that they were entitled to an immediate appeal of the denial of summary judgment, based upon HHS' briefing of the issue of official immunity in support of the corporate defendants' motion for summary judgment pursuant to the "collateral order" exception to the final judgment rule. The corporate defendants also argued that that the Court of Appeals had pendent appellate jurisdiction to review the other grounds advanced by defendants for summary judgment and denied by the District Court. GHI both responded on the merits and moved to dismiss the appeal. On the motion, the Court of Appeals dismissed defendants' appeal for lack of jurisdiction. (Pet. App. A-1 to A-13.) Defendants' petition for rehearing, with suggestion for rehearing *en banc*, was denied on September 29, 1986. The corporate defendants have now petitioned this Court for a writ of certiorari. HHS has not joined in the petition, nor has filed its own petition, and its time to do so has expired.

Factual History [2]

In 1974, GHI purchased Hillcrest General Hospital ("Hillcrest"). Hillcrest was sold by GHI in February 1980. For the years 1974-1980 Hillcrest was an operating component of GHI and had no independent corporate existence. (A. 189.) GHI is a corporation organized under Article 43 of the New York State Insurance Law and is closely regulated by the New York State Insurance Department ("Insurance Department"). Article 43 corporations are statutorily required to maintain a surplus of a certain amount and that statutory surplus or reserve may not be invaded, with certain exceptions set forth in the statute. N.Y. Insurance Law § 4310. In addition to the statutory reserve, certain funds are assigned to cover liabilities and potential liabilities. Any monies of an Article 43 corporation that are not part of the statutory reserve, and are not assigned to liabilities, are referred to as "subscriber funds" or "surplus funds". Ordinarily, under the supervision of the Insurance Department, GHI would invest its subscriber funds in a portfolio of investments.

In January 1973, GHI was exploring the possibility of acquiring a private hospital. GHI proposed to use its subscriber funds to purchase Hillcrest and it was necessary to obtain approval of the Insurance Department before any agreement to purchase could be made. By letter dated June 22, 1973 GHI formally requested approval of the Insurance Department for GHI's planned purchase of Hillcrest. (A. 275-76.)

GHI proposed that it would liquidate its investment portfolio and would use the proceeds to make a cash payment of the full purchase price. Of course, the funds

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[2] Additional facts are set forth in the opinions of the District Court (Pet. App. B-1 to B-5) and the Court of Appeals (Pet. App. A-4 to A-10).

in GHI's investment portfolio were earning a return, and the Insurance Department required that the funds continue to earn a return if they were to be diverted to the purchase of the hospital. Since the payments received for hospital services are almost exclusively made by medical insurance programs, rather than the patients themselves, the Insurance Department's requirement that the surplus funds earn a return required GHI to obtain the approval of the major third-party payors, Medicare, Medicaid and Blue Cross. Blue Cross was the Secretary's fiscal intermediary for the Medicare program for the pertinent geographical area and was the fiscal intermediary for Hillcrest. Blue Cross was also the principal of its own insurance plan. Accordingly, there were meetings and discussions between GHI and Blue Cross concerning the reimbursement by the Medicare program and Blue Cross of such a return.

As subsequently explained during litigation, in Blue Cross' view, the question whether a return on the funds used by GHI to purchase the hospital was reimbursable was not specifically covered by the Medicare regulations and program instructions. Nevertheless, Blue Cross determined that such a return was allowable for Medicare and Blue Cross reimbursement purposes because, in Blue Cross' view, the transaction was analogous to other situations in which reimbursement was allowed and which were specifically addressed in the applicable reimbursement methods. In addition, the rate of return and the exact amount to be allowed each year had been considered in advance and determined to be reasonable. In Blue Cross' determination, the transaction in which GHI diverted its own funds from the investment portfolio to the purchase of a hospital, coupled with the Insurance Department's requirement that there be a return on the use of GHI's funds, was analogous to the situation in which a provider diverts to patient care funds restricted for other uses. (*See* Ingram testimony, A. 310-11, 314.)

Neither the analogy to restricted funds nor the manner of calculating the exact amount to be allowed each year was initiated by GHI. Blue Cross initiated both concepts as is confirmed by the minutes of the GHI Executive Committee held on May 23, 1974. The minutes of that meeting reflect that Joseph R. Fleming stated that "[a] proposal has been sent to Blue Cross, at their request, that GHI make application for a 30-year mortgage on this investment as if it had been loaned from a third party, with interest at 9%." (A. 339.) That is, Blue Cross suggested that the amount to be allowed each year would be determined by an analogy to the amount of interest GHI would have had to pay each year to a bank, if GHI had borrowed from a bank.

A letter dated June 11, 1974 from Lawrence P. Cafasso, the Director of Blue Cross' Provider Reimbursement Division, to Mr. Fleming confirmed that the terms set forth were acceptable to Blue Cross "for Medicare and Blue Cross reimbursement" and set forth the exact rate of the return and the exact amount that could be claimed each year by GHI. (A. 338.)

It was later learned at a hearing before the Provider Reimbursement Review Board ("PRRB") that, in reaching its determination, Blue Cross at no time consulted either HHS or the Association, the prime contractor acting as intermediary, with respect to either the question whether any return whatsoever could be allowed for reimbursement purposes or whether, if such a return were allowable, the manner and amount in which the return could be reimbursed. Neither did Blue Cross ever inform GHI that Blue Cross was required to consult the Secretary on such a ruling or that Blue Cross had not consulted the Secretary. With regard to Blue Cross' determination that such a return would be reimbursable for Medicare purposes, GHI had no reason to believe that Blue Cross was giving anything other than an authorized determina-

tion, *i.e.*, a determination made after consultation with and approval by the Secretary, or a determination that Blue Cross had been delegated the authority to make.

Moreover, it now appears that in reaching its determination that the return was reimbursable Blue Cross was influenced by a desire to purchase hospitals itself, and that Blue Cross therefore viewed a determination that would be favorable to GHI as also benefiting Blue Cross. An internal HHS Report dated August 14, 1978, which was obtained by GHI for the first time in discovery in this case, concluded that:

> By ruling on a complex Medicare reimbursement situation without consulting the Medicare Bureau, Blue Cross may have put its intermediary role second to its own private plan's best interest. This is evidenced by the fact that at the time of the Hillcrest purchase, Blue Cross was interested in purchasing hospitals itself. Blue Cross may have taken an active role and even bent its interpretations of the reimbursement regulations to suit a situation that would act as a catalyst for a reimbursement ruling that it could benefit from in the future.

(A. 361.) In short, unknown to both GHI and the Secretary, it was in Blue Cross' self-interest that a ruling be issued that the return in question was reimbursable by third-party payors, including the Medicare program. (*See* District Court Opn., Pet. App. B-12; Ingram testimony, A. 323-24.)

In accordance with the terms set forth in Blue Cross' letter, GHI included in the hospital's annual cost reports from 1974 to 1980 an amount representing a 9% return on the funds used to purchase the hospital. After GHI had included the return in the hospital's 1974 cost report, Blue Cross audited the hospital and allowed the inclusion

of the return in the calculation of the Medicare and Blue Cross reimbursement rates.

In 1979, Blue Cross, contrary to the approval it had previously given, formally disallowed any return for Medicare and Blue Cross reimbursement purposes and subsequently recouped from GHI any amounts previously paid to GHI that were attributable to the return. (The above allegations were made in paragraphs 17-19 of GHI's complaint and were admitted by HHS in its answer.) (A. 13, 126.) With regard to Medicare reimbursement, Blue Cross changed its position as a result of instructions from the Secretary. By letter to Blue Cross dated September 29, 1978, from Jacqueline G. Wilson, the HHS Regional Director of the Medicare program, Blue Cross was informed that no Medicare reimbursement was allowable and that Blue Cross should never have informed GHI that such a return was allowable for purposes of Medicare reimbursement. Ms. Wilson stated that "we are unable to understand how Blue Cross could have ruled that the 'loan' transaction is a reimbursable cost." (A. 340-41.) GHI appealed the disallowance to the PRRB. The PRRB is part of HHS and was established by 42 U.S.C. § 1395oo(a) to conduct hearings and issue decisions with respect to certain Medicare reimbursement issues. After 60 days, the decision of the PRRB becomes a final decision of the Secretary if the Secretary has not acted to reverse or otherwise modify the decision.

The PRRB, in a decision dated September 19, 1980, held that GHI was not entitled to the inclusion of the return in the calculation of Hillcrest's Medicare reimbursement rate. The decision became final when the Secretary of HHS declined to affirm, reverse or modify. GHI sought judicial review of the Secretary's decision by bringing an action against the Secretary in the United States District Court for the Southern District of New

York, entitled *Group Health Incorporated* v. *Richard S. Schweiker and Provider Reimbursement Review Board*, 80 Civ. 6163 (RLC) ("*GHI* v. *Schweiker*"). In *GHI* v. *Schweiker* the District Court granted the motion of defendant Secretary for summary judgment. *Group Health Incorporated* v. *Schweiker*, 80 Civ. 6163 (S.D.N.Y. March 22, 1982), *aff'd*, 742 F.2d 1434 (2d Cir. 1983), *cert. denied*, 467 U.S. 1225 (1984). The District Court ruled that the Secretary had disallowed the return because such a return was not reimbursable under the Medicare program, and that Blue Cross' written ruling to the contrary was perhaps colored by its own self-interest. In an order not-for-publication or use in other cases, the United States Court of Appeals for the Second Circuit affirmed the decision of the District Court. GHI's petition for a writ of certiorari was denied by order of the Supreme Court of the United States dated June 4, 1984.

Subsequently, GHI instituted this action alleging, *inter alia*, negligence, misrepresentation, and breach of warranty of authority by Blue Cross. The complaint alleges that, as a result of Blue Cross' negligence and wrongful actions, GHI was damaged in that it received no return on the funds used to purchased Hillcrest. Had Blue Cross consulted the Secretary as it should have, GHI would have learned in 1974 that the Medicare program would not pay the return on the funds GHI used to purchase Hillcrest. GHI then could have acted to obtain a return by either restructuring the financing or selling Hillcrest and returning the purchase funds to the GHI investment portfolio.

The Decisions Below

By opinion filed August 16, 1985, the District Court (Leisure, J.) denied the corporate defendants' motion for summary judgment. (Pet. App. B-1 to B-23.) With regard to HHS' argument that the corporate defendants are en-

titled to official immunity, the District Court applied a balancing test in determining that the corporate defendants, large private insurance corporations, should not be deemed federal officials for immunity purposes. (Pet. App. B-14 to B-20.) In addition, the Court held that even if the corporate defendants could be deemed federal officials, the existence of a question of fact concerning the scope of Blue Cross' authority precluded summary judgment. (Pet. App. B-19 to B-20.)

Defendants appealed the District Court's decision to the United States Court of Appeals for the Second Circuit, alleging that the denial of the claim of official immunity satisfied the "collateral order" exception to the final judgment rule. The Court of Appeals dismissed defendants' appeal for lack of jurisdiction. (Pet. App. A-1 to A-13.) The Court of Appeals held that the decision appealed from did not fall within that small class of cases encompassed by the collateral order doctrine. The Court reached this decision for two reasons. First, the immunity question could not be decided without addressing GHI's underlying claims on the merits, including such essential disputed questions as whether Blue Cross acted within the scope of its authority. Second, the Court found the case was "too inchoate and tentative for [it] to undertake appellate jurisdiction" and that the interest of judicial economy would best be served by allowing this present action to proceed together with GHI's action against the United States under the FTCA, *GHI* v. *United States*, which had previously been ordered consolidated with the present action. (Pet. App. A-3, A-12.)

As a basis for granting their petition for a writ of certiorari, the corporate defendants allege that the decision of the Court of Appeals conflicts with decisions of this Court. As demonstrated below, this is incorrect, and accordingly, the petition should be denied.

The Petition Should Be Denied

The Court of Appeals' holding is correct and does not conflict with any decision of this Court. Further review is not warranted.[3]

1. Petitioners have not raised a substantial claim of official immunity.

Petitioners contend that the Court of Appeals' decision conflicts with decisions of this Court. They do not contend that the decision conflicts with a decision of any other Federal Court of Appeals.[4] Petitioners cite to prior decisions of this Court holding that, under the facts presented in those cases, the denial of a claim of absolute or qualified immunity was immediately appealable pursuant to the collateral order exception to the final judgment rule. *See Mitchell* v. *Forsyth*, 472 U.S. 511, 105 S.Ct. 2806 (1985) (Attorney General qualified immunity); *Nixon* v. *Fitzgerald*, 457 U.S. 731 (1982) (Presidential immunity); *Helstoski* v. *Meanor*, 442 U.S. 500 (1979) (Speech and Debate Clause); *Abney* v. *United States*, 431 U.S. 651 (1977) (Double Jeopardy Clause). Petitioners' reliance on these cases is misplaced and their contention incorrect. There is no direct conflict between the decisions cited and the Court of Appeals' decision to dismiss the appeal in the circumstances presented in this case.

In order to come within the small class of cases excepted from the final judgment rule established by this

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[3] The government's decision not to join in the corporate defendants' petition, or file a petition itself, is instructive on the issue of whether grounds for the granting of a petition for a writ of certiorari exist.

[4] Petitioners also contend that the decision below raises an important question of federal law. However, petitioners nowhere explain what important question of federal law is raised.

Court in *Cohen* v. *Beneficial Industrial Loan Corp.*, 337 U.S. 541, 546 (1949), the trial court's order must meet the following conditions:

> [F]irst, it "must conclusively determine the disputed question"; second, it must "resolve an important issue completely separate from the merits of the action"; and third, it must "be effectively unreviewable on appeal from a final judgment." [Citations omitted.] In addition [fourth], *Cohen* established that a collateral appeal of an interlocutory order must "presen[t] a serious and unsettled question," 337 U.S. at 547, 69 S.Ct. at 1226. *See Nixon* v. *Fitzgerald*, 457 U.S. 731, 742, 102 S.Ct. 2690, 2698, 73 L.Ed.2d 349 (1982).

In Re "Agent Orange" Product Liability Litigation, 745 F.2d 161, 163 (2d Cir. 1984).

Where the claim for immediate appeal is based upon an order denying a defense of official immunity, there is the additional requirement that the appellant present a "substantial claim" of official immunity. *Mitchell* v. *Forsyth*, *supra*, 472 U.S. at —, 105 S.Ct. at 2815.

Initially, the petition should be denied since petitioners do not have a "substantial claim" of immunity such as may be subject to immediate appeal. Blue Cross and the Association are not, in fact, federal officers. They are large, private corporations that are either a contractor or a subcontractor of an agency of the federal government.[5] The phrase "federal official" most aptly describes an individual, as opposed to a corporation, that is actually an official of the federal government. A contractor, or

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[5] The petitioner Association entered into a contract with HHS pursuant to which the Association agreed to act as a fiscal intermediary for HHS under the Medicare program. The Association then subcontracted a portion of this work to the petitioner Blue Cross.

subcontractor, of an agency of the government is not a federal official. Thus, at most, petitioners' argument is that they should be "deemed" to be federal officials, for purposes of immunity. If they were first "deemed" federal officials, it would then be required to determine whether they would be entitled to official immunity under the circumstances of this case. No case has been found which holds that the denial of a private corporation's claim that it should be "deemed" a federal official is a collateral order under the *Cohen* doctrine. Petitioners' argument begs the question to be addressed. They first assume that they are federal officials. Then having assumed what it is to be proven, they argue from cases involving the application of the immunity doctrine to actual federal officials.

Moreover, the petitioners neither raised the defense of official immunity in their answers nor moved for summary judgment on the ground of official immunity. In fact, in arguing a prior motion, the petitioners specifically stated that they were *not* contending that they were officers of the United States. (Defendants' Memorandum of Law in Opposition to Plaintiff's Motion for Removal, dated April 2, 1982, p.8.) A claim that is waived by failure to plead it as an affirmative defense in an answer, and is contradicted on a prior motion, certainly does not present the "substantial" claim of immunity as required for the "collateral order" exception.

The issue was first raised by the government as an intervenor defendant, and the government has not petitioned for a writ of certiorari. The fact that Blue Cross and the Association never raised the issue of official immunity in their answers, or on their motion for summary judgment, or at any time in the District Court, is telling testimony that the claim is not substantial; Blue Cross and the Association recognized that they were not entitled to official immunity.

2. The District Court's order does not resolve a purely legal issue that is completely separate from the merits and therefore the order does not satisfy the *Cohen* criteria.

Petitioners also contend that the Court of Appeals erred in holding that their claim was not separate from the merits of GHI's claim.[6] Petitioners essentially argue that a cry of "official" immunity automatically satisfies the requirements of the collateral order doctrine and that factual disputes do not preclude a court from ruling on a claim of official immunity. Petitioners' contentions are incorrect.

In order to even be considered for immediate appeal under the collateral order exception, the interlocutory order must present a purely legal issue. *See, e.g., Coopers & Lybrand* v. *Livesay*, 437 U.S. 463, 476 (1978) (disputed factual questions preclude appeal of nonfinal order). This requirement has received special emphasis by the courts where the interlocutory order denied summary judgment on a claim of official immunity. *E.g., Mitchell* v. *Forsyth, supra*, 472 U.S. at —, —, 105 S.Ct. at 2816 n.9, 2817 (emphasizing that appealable issue is "purely a legal one" and holding that a denial of qualified, official immunity from constitutional tort is immediately appealable "to the extent that it turns on an issue of law"); *Williams* v. *Collins*, 728 F.2d 721, 726 n.7 (5th Cir. 1984) ("[M]any denials of claimed immunity in pretrial proceedings will not be in a posture for appellate review, in that entitle-

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[6] It is significant to note that in the Court below HHS admitted that the claim of immunity was not completely separate from the merits of the case. In arguing in favor of the Court of Appeals exercising "pendent" jurisdiction over issues in addition to official immunity, HHS asserted that "[i]n this case, certain factors must be considered on the official immunity claim also must be considered in assessing the adequacy of GHI's misrepresentation claims." (Brief of Intervenor-Defendant-Appellant, p. 15.)

ment to immunity will turn on disputed questions of fact or will otherwise be inextricably bound up with the merits of the claims."); *Evans* v. *Dillahunty*, 711 F.2d 828, 830 (8th Cir. 1983) (motions premised on absolute or qualified immunity are immediately appealable only in cases where: (1) the essential facts are not in dispute, and (2) the determination whether the government official is entitled to immunity is solely a question of law). Thus, like the Second Circuit, other Courts of Appeals have recognized that to even be considered for immediate appeal, a purely legal issue must be presented.[7]

Here, GHI has demonstrated a factual dispute as to whether Blue Cross' actions were authorized. Thus, even if it were to be assumed for purposes of argument that petitioners were to be deemed federal officials for immunity purposes (the District Court held that they were not to be so deemed), petitioners' claim does not satisfy the collateral order exception.

One of the reasons that Blue Cross acted negligently is that Blue Cross did not, in fact, have the authority to

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[7] Petitioners read this Court's prior decisions too broadly. *Nixon* v. *Fitzgerald* does not hold, as petitioners contend, that claims of official immunity will always be collateral to the merits of the underlying action. Rather, whether a claim of immunity is collateral will depend on the specific facts involved in any particular action. The analysis of the Court below is consistent with other Courts of Appeals on this issue. *See, e.g., Williams* v. *Collins, supra*, 728 F.2d 721; *Evans* v. *Dillahunty, supra*, 711 F.2d at 830. Similarly petitioners misread *Abney* v. *United States* and *Mitchell* v. *Forsyth* as standing for the proposition that claims of immunity will always present questions of law for a court to determine, even if such a determination involves resolving questions of fact. Again, under the facts presented, this Court, in those two prior cases, determined that the issue presented in each case was a legal one for the Court to determine. While this Court's holdings in those cases provide instruction to lower courts in analyzing the application of the collateral order doctrine to immunity claims, they do not dispose of the need for individual analysis.

issue to GHI the advance written ruling that the item in question was reimbursable under the Medicare program without first consulting with the Secretary. Presented with a request for an advance ruling, which was beyond the petitioners' authority to issue, the proper procedure was to consult the Secretary. In arguing that the District Court's order denying summary judgment is "completely separate" from the merits, the petitioners once again attempt to assume their own version of a material issue of fact going to the merits, *i.e.*, that Blue Cross was, in fact, acting within the scope of its authority. To the contrary, an internal HHS report dated August 14, 1978, concerning Blue Cross' actions, concluded that:

> By ruling on a complex Medicare reimbursement situation without consulting the Medicare Bureau, Blue Cross may have put its intermediary role second to its own private plan's best interest. This is evidenced by the fact that at the time of the Hillcrest purchase, Blue Cross was interested in purchasing hospitals itself. Blue Cross may have taken an active role and even bent its interpretations of the reimbursement regulations to suit a situation that would act as a catalyst for a reimbursement ruling that it could benefit from in the future.

(A. 361.) Ms. Jacqueline Wilson, Deputy Regional Director of HHS, testified at her deposition that, based on the above report, it appeared that Blue Cross may have over-extended its authority. (Deposition of Ms. Wilson, A. 385.) Ms. Wilson testified that an intermediary should not give a ruling or determination involving a policy question without consulting in advance with HHS. Ms. Wilson also testified that a ruling creating a new exception to those listed in section 405.419(c) of 42 C.F.R. would be a policy determination as would a ruling or determination that a certain transaction would be construed as one of the exceptions listed in section

405.419(c).[8] (Deposition of Ms. Wilson, A. 397-402.) Blue Cross acted beyond its authority in ruling, without consulting HHS, that a return on the funds used by GHI to purchase Hillcrest could be construed as the equivalent of the exceptions in section 405.419(c) of 42 C.F.R.

Moreover, in the somewhat similar factual situation presented in *Heckler* v. *Community Health Services of Crawford County, Inc.*, 467 U.S. 51 (1984), this Court held that

> It is undisputed that correct administrative practice required [the fiscal intermediary] to refer [the provider's] inquiry to the Department of Health and Human Services for a definitive answer.

Id. at 57.

3. The instant order can be effectively reviewed upon final judgment and therefore it does not satisfy the *Cohen* criteria.

The cases that hold that the denial of certain claims of absolute immunity are immediately appealable are based on the recognition that the claimed immunity, if established, is an entitlement not to stand trial. *See, e.g., Mitchell* v. *Forsyth, supra*, 472 U.S. at —, 105 S.Ct. at 2815. The reasoning is that entitlement to be free from trial is effectively lost upon the denial of an interlocutory motion that allows the case to proceed to trial. Petitioners rely heavily on this entitlement not to stand trial in arguing for the granting of their petition for a writ of certiorari. However, the rationale underlying the categorization of certain immunity defenses as an "entitlement not to stand trial" is not applicable here.

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[8] Section 405.419(c) of 42 C.F.R. prohibits, for Medicare purposes, the reimbursement of interest on loans between related entities.

The rationale underlying official immunity, and the rationale for characterizing that immunity as an immunity from standing trial, is that if an individual serving as a federal official must litigate to defend himself from personal liability, the litigation might distract the individual from the performance of his governmental duties, might unduly intimidate him in the performance of discretionary duties, and might deter able people from public service. *See Mitchell* v. *Forsyth*, *supra*, 472 U.S. at —, 105 S.Ct. at 2815; *Harlow* v. *Fitzgerald*, 457 U.S. 800, 816 (1982); *Gregoire* v. *Biddle*, 177 F.2d 579, 581 (2d Cir. 1949), *cert. denied*, 339 U.S. 949 (1950).

This rationale simply does not apply with equal force to a claim advanced on behalf of the private corporate petitioners that they should be "deemed" to be federal officials. Blue Cross is not an individual serving as a federal official; it is a large and powerful private corporation that operates its own hospital insurance plan and has entered into a contract to perform services for the Association. If Blue Cross is held responsible for its own tortious conduct, as is any other private corporation, there will be no significant diversion of "time and energy that would otherwise be devoted to government service." With respect to its own hospital insurance program, and any other of its corporate undertakings, Blue Cross is liable for its own torts and must defend itself. Blue Cross' defense in those cases does not consume time and energies that would otherwise be devoted to government service and neither would its defense of its own tortious conduct in the context of its contract with the Association. *Cf., e.g., Jackson* v. *Kelly*, 557 F.2d 735, 739 (10th Cir. 1977); *see Ferri* v. *Ackerman*, 444 U.S. 193, 204 (1979).

Petitioners make much of this Court's remarks in *Barr* v. *Matteo*, 360 U.S. 564 (1959). Such remarks, however, obviously indicate that this Court envisioned an individual working for the government as the "federal official" and did not have in mind a large private corpo-

ration which, in addition to its other contracts, happens to have a contract with a contractor of the federal government. A corporate contractor, unlike the individual federal official envisioned by this Court in *Barr* v. *Matteo* and by Judge Hand in *Gregoire* v. *Biddle*, can simply hire more employees if it has more work to do. The underlying rationale of the immunity concept simply does not pertain to the facts of the instant case.

Similarly, a moment's reflection reveals that Blue Cross is not likely to be intimidated in the performance of its contractual obligations to the Association by the fact that it will be held liable for its own tortious conduct. All private corporations are held accountable for their own torts, as is Blue Cross in the administration of its own hospital insurance plan. *Cf., e.g., Jackson* v. *Kelly, supra*, 557 F.2d at 739; *Franks* v. *Bolden*, 774 F.2d 1552, 1555 (11th Cir. 1985). The legal fees and other expenses that are attendant to any such legal defense are a cost of doing business and are figured into the prices charged, the amounts that may be bid for contracts, etc. In short, whereas an individual's ardor might well be unduly dampened by the possibility of a judgment for monetary damages, the same effect is much less likely to follow with respect to a corporate contractor. Blue Cross acts through its individual officers and employees and, since they are not being sued here, the rationale based upon a federal official being intimidated by the threat of defending himself against allegations of tortious conduct simply does not apply. Under modern business conditions it is pure fiction to suggest that the rationale underlying the concept of immunity for federal officials applies to a corporation that contracts or subcontracts to act as a fiscal intermediary in the Medicare program.

The issue whether a private corporation should be "deemed" to be a federal official is an issue upon which the private corporation must carry the burden of proof and the burden of persuasion, *i.e.*, assuming for purposes

of argument that the defense is available, the private corporation must litigate to establish that it should be so "deemed". *See generally Boyd* v. *Carroll,* 624 F.2d 730 (5th Cir 1980) (involving claim that a private citizen should be entitled to status as a "judge" under facts of case). A private defendant cannot simply assert that it should be "deemed" to be a federal official and then, by bootstrap logic, claim that as a federal official it has an entitlement not to stand trial on the very question whether it should be deemed a federal official in the first place.

With respect to the issue of official immunity, the District Court decided that Blue Cross and the Association cannot be deemed federal officials for purposes of immunity. (Pet. App. B-14 to B-20.) In addition, the District Court found that it had not been established as a matter of law that Blue Cross was acting within the scope of its authority with respect to the actions complained of. (Pet. App. B-11 to B-13.) Accordingly, the denial of the instant claim, like the myriad of other claims that may be raised and denied on summary judgment motions, is subject to appeal following trial under the final judgment rule. Of course, if upon review following final judgment, the claim rejected by the trial court is ultimately upheld on appeal, the party whose claim for summary judgment had been denied will have suffered the detriment of unnecessarily standing trial. However, as stated by the Court of Appeals for the Second Circuit in rejecting the appealability of the immunity claim raised in *In Re "Agent Orange" Product Liability Litigation, supra,* "[S]uch possible harm does not outweigh the strong policies of the final judgment rule." 745 F.2d at 166.

4. Piecemeal appeal is especially unjust in the instant case and allowing an immediate appeal would not materially advance the ultimate termination of the litigation.

Petitioners contend that the Court of Appeals incorrectly considered the existence of GHI's action against the United States, which has been consolidated by the District Court with the instant action. Petitioners' contention is incorrect.

Initially it should be pointed out that petitioners have not cited to any decision of this Court where such an analysis was disapproved. In any event, the Court of Appeals' consideration of the consolidated FTCA action was entirely proper.

The final judgment rule is an expression of several important policy considerations. One of the most important of these considerations is that the final judgment rule preserves scarce judicial resources. *See Coopers & Lybrand* v. *Livesay*, *supra*, 437 U.S. 463. Because of the final judgment rule, a Court of Appeals does not have to waste time becoming familiar with a case anew each time a partial appeal is taken. Moreover, if the aggrieved party obtains a final judgment in his favor, the issue on the interlocutory order may become moot, eliminating any need for appellate review. The final judgment rule assures that a Court of Appeals will not have wasted its time reviewing potentially moot, interlocutory orders. The Second Circuit's consideration of the claims and defenses in the consolidated FTCA action is consistent with this important policy consideration.

The Court of Appeals' consideration is especially appropriate where, as recognized by the Court of Appeals, the petitioners have a history of taking inconsistent legal positions with respect to the facts underlying GHI's

claims for relief. For example, in GHI's prior action for judicial review of the Secretary's administrative determination to deny payment under the Medicare program, the government vigorously and successfully argued to the Court that it had never been consulted by Blue Cross prior to Blue Cross' written ruling, that Blue Cross' actions were unauthorized and that the government could not be estopped by the *unauthorized* actions of its agent, Blue Cross. One point of the Secretary's appellate brief in *GHI* v. *Schweiker* was entitled: "[POINT III] B. The Secretary Cannot Be Estopped From Denying The *Unauthorized* Acts Of His Agents". (Brief for Appellees [HHS and PRRB], *GHI* v. *Schweiker*, No. 82-6134, p.26, emphasis added.)[9]

In the instant action against Blue Cross and the Association, GHI asserts, *inter alia*, that Blue Cross'

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[9] This point in the government's brief contained the following argument:

> Even assuming arguendo that the elements of estoppel are established and that sovereign functions could be estopped, plaintiff's claim still falters. The United States cannot be bound by the *unauthorized* acts of its agents *nor estopped to assert their lack of authority.* [Citation omitted.] The Government could scarcely function if it were bound by its employee's *unauthorized* representations. [Citation omitted.]

(Brief for Appellees, *GHI* v. *Schweiker*, p.26, emphasis added.) HHS took the position that Blue Cross issued an advance determination, without prior consultation with the Secretary, that a type of expense was reimbursable under the Medicare program, when it had no authority to do so:

> Intermediaries are authorized to "serve as a channel of communication for providers to the Secretary," provide consultative services to the Secretary, and communicate to providers both information and instructions furnished by the Secretary. 42 U.S.C. § 1395h(a); 42 C.F.R. § 405.401(e), 405.406(b). They are *not* authorized to make final and binding determinations involving millions of dollars where they have not even consulted with the Secretary . . . .

Id. at p.30n. (emphasis in original).

issuance of its advance written ruling was beyond the scope of its authority, and that Blue Cross was negligent in not consulting the Secretary prior to issuing its written ruling. Now, HHS and petitioners argue that Blue Cross' action *was* authorized and that Blue Cross did *not* have to consult the Secretary prior to issuing its written ruling. *E.g.*, Brief [to Court of Appeals] for Intervenor-Defendant-Appellant [HHS], p.21.

As stated above, on GHI's instant claim against the petitioners, the government takes the position that Blue Cross' actions were authorized and within the scope of Blue Cross' duties as a fiscal intermediary. Yet in GHI's consolidated action, which asserts an alternative theory of liability against the United States under the FTCA, the government denied GHI's allegation that Blue Cross was acting within the scope of its employment with respect to the actions complained of. (A. 126, Answer of the United States, *GHI* v. *United States*, § 2, denying the allegations of paragraphs 38, 44 and 51 of GHI's FCTA complaint, A. 35, 36, 37.) Paragraph 38 of the GHI complaint alleged, "Any actions or omissions of Blue Cross and its officers and employees in the exercise of the activities of a fiscal intermediary were the actions and omissions of employees of the Government *acting within the scope of their employment.*" (A. 35, emphasis added.) Paragraphs 44 and 51 of the GHI FTCA complaint made the same allegations as to the other defendants. (A. 36, 37.) As the Court of Appeals stated:

> [I]n the FTCA suit, the government claims, interestingly enough, that the intermediaries are *not* its agents. Burrowing to the root of this tangle, it becomes clear that these contradictory claims are interrelated. Moreover, in their present posture the cases are too inchoate and tentative for us to take appellate jurisdiction.

(Pet. App. A-3, emphasis in original.)

Again, as noted above, Blue Cross and the Association claimed that they were *not* federal officials in arguing the removal motion, but in arguing the issue of immunity, petitioners argue that they *are* federal officials.

Faced with the inconsistent positions already taken by the petitioners, and the strong possibility of the petitioners taking inconsistent positions on numerous future issues, GHI consolidated the two actions and has, in effect, argued alternative theories of liability against the various defendants. The facts show that GHI suffered a wrong as the result of Blue Cross' actions and that at least one of the defendants is liable. Consolidating the various claims should prevent the defendants from escaping on a theory of liability by arguing facts, and taking legal positions, that will prove them liable under an alternative theory of liability.

Under these circumstances, permitting piecemeal appeals of decisions ruling on only a portion of the legal issues would be egregiously unfair to GHI. Piecemeal appeals would allow the defendants the opportunity to attempt to defeat each alternative theory of liability one-at-a-time by taking inconsistent positions. For example, if the Court of Appeals were to rule that the petitioners were immune from liability because they were directed by the government to take the actions complained of, piecemeal appeals would offer the defendants the opportunity in subsequent proceedings to avoid alternative theories of liability by arguing that Blue Cross' actions were unauthorized and beyond the scope of their agency.

Moreover, if the government is correct that GHI does not have a remedy against the United States under the FTCA, and that an estoppel argument does not lie against the Secretary, then the lack of these remedies should be considered by the Court of Appeals in deciding whether a private corporation should be "deemed" a federal official

and whether immunity from their own negligence and other tortious conduct should be extended to such private defendants. Under these circumstances, the most appropriate, and most fair, way for such appellate determinations to be made is after complete development of the facts, and on one appeal after final judgment.

Petitioners' argument, that pursuant to the Court of Appeals' rationale immediate appeal of the denial of a claim of official immunity could be thwarted by bringing more than one action, is frivolous. The Court of Appeals' decision turned on the specific facts presented to it and any such improper actions as foreseen by petitioners would be adequately dealt with by the courts, should they ever occur.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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